



CANS

NEWSLETTER

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CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC.

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President's Message

Patrick J. Wade, M.D.

At the recent AANS Meeting, the Council of State Neurosurgical Societies (CSNS) tackled a number of issues, particularly manpower and reimbursement. Dr. Smith will discuss this in detail in his message. Most resolutions dealt with the availability of emergency care, the 80-hour work week for resident training and pay for performance (P4P).

The simple fact is there are twice as many hospitals as there are Neurosurgeons in the United States. In certain areas, especially in California, Neurosurgeons are not available at any price. As far as the 80-hour work week for resident training is concerned - it's here, it's dear, and it's in our face. It is unlikely to change in the foreseeable future. You never minded your indentured servitude, did you?

The AMA, CMA, and now the CSNS, have come out strongly opposed to any programs like the P4P.

The Governor, at the CMA Legislative Day, April 24, 2007, stated clearly that the Kuehl Bill, or any other Government run single payer health care program, will not pass. Or to use his analogy, Government run universal single payer will be like going to the DMV for your health care.

Speaker Nuñez and President pro Tem Perata have combined their bills in committee and now they go to Appropriations for review. This Democratic united front will make negotiations more difficult for the Governor. A coalition of the CMA, Unions, and health care insurers have been meeting to plan mutual strategy.

There is a realization by most legislators on both sides of the aisle that California reimbursement for MediCal and other health insurance is inadequate. We cannot retain our own medical school students and residents. Our cost of living is too high and the reimbursement too low.

One proposition, which would be nice, but seems unlikely, is to raise MediCal reimbursement to 80% of Medicare levels. With that I recommend you enjoy the springtime and smell the roses; they are in full bloom. ❖

Assisted Suicide and You

Randall W. Smith, M.D., Editor

As you probably know, an assisted suicide bill *ala* Oregon has been introduced in the California State Assembly and has passed out of the Judiciary Committee. CANS has yet to take a position on this bill but it will be discussed at the imminent CANS Board meeting on 5/5/2007 in Los Angeles. CANS members' input is welcome and your comments can be sent to our Executive Secretary Janine Tash (janinetash@sbcglobal.net). Considering some of the patients neurosurgeons care for, we can expect to be involved in patient requests for assistance with suicide if such a bill becomes law. Of some interest is the support for the bill expressed by the California Association of Physician Groups (CAPG) which claims to speak for 59,000 California physicians which probably includes all the readers of this newsletter. CAPG is an organization to which over 150 physician groups belong, including Kaiser physician groups and many IPAs. I believe most physician groups joined this organization upon the decision of the physician groups' administrators in the hopes of furthering their business interests when dealing with insurers such as claims payment timeliness as well as assistance in determining a group's tangible net equity and other fiscal issues. The member phy-

Inside this issue:

CSNS Resolutions - page 2

Guest Editorial - page 3

Discectomy an Amputation? - page 4

CA Health Plan, the Legislature & CMA - page 4

Farewell to an Old Friend - page 4

Neurosurgical Positions - page 4

Executive Office Report - page 5

correction to previous newsletter - page 5

sician groups might be surprised to learn that CAPG claims to be the voice of organized medicine in California (which might be a news flash for the CMA—which opposes the suicide bill). The CAPG’s website includes a mission statement embracing quality, accountable medical care and states it is a trade association representing physician groups involved in mostly risk sharing contracts with insurers. The mission statement seems reasonable but the claim to be the voice of organized medicine or really represent the views of the 59K docs who are members of or contracted with physician groups is hardly accurate. It would seem a limited group of CAPG directors has engaged in organizational aggrandizement. CAPG probably does represent the business interests of about 500 physician group CEOs, COOs and CFOs, but trying to cloak itself in physician representation garb may result in the embarrassing realization that the Emperor’s new clothes are an illusion.

If you feel strongly about the assisted suicide issue or the CAPG misrepresentations, you might consider calling the CEO of the medical groups with which you are contracted or a member and express your opinions. ❖

CSNS Resolutions Considered

Randall W. Smith, M.D.

The fifteen resolutions listed below were debated and acted upon (as indicated in bold type) at the Council of State Neurosurgical Societies (CSNS) meeting on April 13-14 in Washington, DC. It is to be noted that approved resolutions are advisory to the AANS and CNS and may be embraced or rejected by those bodies.

Resolution I – Wants the skills necessary to cover the ED defined, incorporated into training programs and CME. **Referred to committee for more details.**

Resolution II – Wants the resident 80-hour work week embraced as adequate for 4-5 year training programs w/o the need for fellowships. **Rejected.**

Resolutions III, IX – Wants the AANS to report member disciplinary actions to state medical boards and require disciplined members to perform special ethics and medical testimony CME before reinstatement. **Rejected the reporting requirement but approved mandatory CME related to cause for discipline.**

Resolution IV – Wants an evaluation of training programs to discern whether the apprenticeship model generally used is due for change to better meet the needs of trainees, patients and society. **Referred to committee for more details.**

Resolution V – Wants AANS/CNS to create a “health grades” site with accurate information to counter proprietary grading sites like WebMD and others which often contain erroneous information. **Referred to committee for more details.**

Resolution VI – Wants the AANS/CNS/AMA to campaign for passage of national legislation to legalize collective bargaining by groups of physicians. **Approved.**

Resolutions VII, X, XI – Want to oppose the feds pay for performance and public reporting initiatives. **Approved.**

Resolution VIII – Wants the AANS/CNS to create national determination of brain death guidelines. **Approved.**

Resolution XII – Wants AANS/CNS to create a voluntary outcomes registry for neurosurgeons to contribute to and access for personal use such as practice improvement and justification for surgical recommendations. **Approved.**

Resolution XIII – Wants AANS/CNS to work with the RRC and the ABNS to create a curriculum and certificate in critical care for neurosurgeons so as to qualify as “intensivists” in the ICU. **Rejected.**

Resolution XIV - Wants AANS/CNS to classify their CME credits denoting such areas as “pain” and “trauma,” among others, as well as offering seminars in those topics to assist in satisfying various state medical board CME rules. **Approved.**

Resolution XV – Wants the AANS/CNS to work with the AMA and imaging software manufacturers to create a digital image viewing program allowing any reader to view the images. **Approved.** ❖

Guest Editorial: Should Surgeons be Paid for ER Coverage?

Moustapha Abou-Samra, M.D., Ventura

The end of the world must be coming; physicians want to be paid to take call! Our local paper published an article about that a couple of weeks ago. It was interesting to see readers' reaction: many suggested that physicians should stop whining and do what they are supposed to do-show up at all hours to take care of all comers to the ER. Getting paid? No, it is part of the job. Do you know any other professional or trade group that is willing to be on call without getting a fair compensation? There is no such entity. Even our colleagues, the disciples of Florence Nightingale, get paid to be on call!

I completed my training in 1980. Then, it was a given that physicians and surgeons took call at their local Emergency room(s). No one questioned the wisdom of doing that and everyone participated. Back then, and even though I had a young family, and very young children, it never occurred to me that taking call was negotiable; in fact, I felt, much like most, that it is an obligation and a privilege - being available to take care of our community members when they needed us most. It was the Natural thing to do. It was the Right thing to do!

I continued to take call without compensation for 23 years ...

Three years ago, my youngest partner, a well trained, decent and hard working family man decided that unless we get paid for ER call, we should stop providing the service ... it was a shock to me. I knew that compensation for ER call in California was becoming common place, mostly because it is difficult for hospitals to find neurosurgeons to cover their ERs, but I never thought that we, in sleepy Ventura County, were prone to this "illness." I was ambivalent about the whole idea.

I did not think that our hospital would agree to such a thing; it was, after all, a non-profit hospital, and it simply couldn't afford such nonsense. My young partner succeeded in negotiating a deal with our local hospital and the administration agreed, without much fuss, to pay us for taking call. So since July of 2004, we get paid to take ER call at my local Community Hospital and I find myself giving my call away as often as I can.

I simply do not want to take call anymore. Here are my reasons, and none involves financial remuneration.

Emergency rooms are no longer called ERs. They are called EDs and I think the "D" should stand for dysfunctional. I don't know all of the Emergency Department physicians anymore and I don't know a lot of the Hospitalists, who seem to control the flow of patients in modern day hospitals. They don't know how I think and I don't know how they do, that is if they think at all beyond following a flow chart that keep them adhering to the way the "system" is supposed to work, a system that is designed to keep them and the hospital out of trouble.

How else will you explain the call I received this week, asking me to consult on a patient who presented to the ED with left shoulder and arm pain associated with numbness of the left hand. The call came to me, after a cardiologist already performed a coronary angiogram and ruled out coronary artery disease. The hospitalist, in fact, already decided that the next step is to make sure that the cervical cord is OK. An MRI scan was already done, before I was called - but, of course, no C-Spine X-rays. History taking was essentially not a part of the investigative process.

When I interviewed the patient, who was eating her dinner, she looked very comfortable. She admitted to having suffered from the same symptoms for at least three years and that she has been on disability for as many years. She said that she had consulted several physicians, including neurosurgeons and orthopedic surgeons in Los Angeles, before moving to our County. She admitted that she came to the ED because she no longer has her pain medications. The one that was of particular interest to her was the Fentanyl patch; it is very effective doctor!

I actually don't blame ED physicians and hospitalists; after all, they have to practice defensive medicine. Tort reform is a must, but will be the subject of another essay.

In the past, young physicians built their practices and reputations by seeing people in the ER. This is no longer possible. If you have health insurance coverage-and more than 40.000.000 of us don't - you are likely attached to an HMO or an IPA, and it is not possible to gain a new patient if you are not on their panel. And if you don't "belong" to them, they refuse to pay you your customary fee anyway. Our Governor tried to force us to accept their fees as full payment, even if we are not contracted with them. He failed, but you know that he will try again.

EMTALA made things even worse. I will say that it was a well intended Federal legislation, but as we all know the road to hell is paved with good intentions. Among other things EMTALA expects us to do, is see any patient when called by an ED physician and or his designee. We can't refuse.

When it comes to Neurosurgery specifically, our specialty has changed so much with all our technical advances that a significant number of real emergencies are best treated in a tertiary center, and should be transferred there. A perfect

example is acute subarachnoid hemorrhage. Manning an ED at a hospital that is not equipped to handle such cases puts us in an awkward position, to say the least.

And yes, let's talk about quality of life issues. As more and more women join the ranks of our profession, we are hearing more and more that spending quality time with our families is essential, in fact, desirable. I agree; we should have started paying attention to life style issues, our families and our own mental and physical health, long ago.

No, I no longer have a philosophical objection to being paid for ED call. The hospitals actually can afford our relatively cheap compensation, and some of us can't make ends meet without such compensation. However, I predict that getting paid to take call is the first step down the road to being required to do so. I know that there were several propositions that would have dictated how much we should be paid and there are groups that are pushing for mandatory ER coverage in exchange for hospital privileges or participation in Medicare. More propositions will be submitted in the future, I am certain of that. The powerful American Hospital Association is behind many of them.

I, for one, feel that they can never pay me enough to take call in a modern day ED. Life is simply too short.

Is it the end of the World? No, but it is a very different World, indeed! ❖

Other News

Randall W. Smith, M.D.

Discectomy an Amputation?

It is noted that a number of Workers' Compensation Appeals Court judges have reached dueling rulings about what constitutes an amputation. The import of this is that if an injured worker undergoes an amputation, the limit of 104 weeks of temporary total disability (TTD) payments per injury is waived and payments may continue. The rulings have been about whether or not a discectomy, corpectomy or graft harvesting for fusion constitute an amputation. The ludicrous nature of attorney/judges making this decision aside, how it finally comes down can affect neurosurgeons' work comp patients since we often get these patients after a considerable period of TTD during which they undergo PT, electrodiagnostic tests, multiple scans, chiropractic, injections galore, pain management and bureaucratic delays. As we finally commence definitive treatment like a discectomy and fusion, it would be useful if TTD payments continue during the surgery recovery phase rather than throwing the patient into his/her savings or onto welfare in order to survive. If declaring discectomy an amputation is what it takes to get these benefits for our patients, then (laughter) so be it. ❖

CA Health Plan, the Legislature and the CMA

The democratic leaders in the state Assembly and Senate, who have proposed dueling legislation to improve healthcare coverage for the uninsured, are making sounds of a rapprochement combining their bills into one they feel can pass both houses. How the governor would deal with this is unknown. The CMA appears to be sitting back, letting the solons thrash this out and generally cheer on the legislators who present separate bills that do not include a tax on physicians. Of additional note, the CMA Board of Trustees at their 4/12/07 meeting did endorse the Health Care Antitrust Improvement ACT of 2007 which would legalize collective bargaining by groups of physicians as they deal with third party carriers without fear of violating antitrust laws. ❖

Farewell to an Old Friend

Julian (Buz) Hoff, former neurosurgical chair at UCSF and for many years the chair at the University of Michigan, died recently after a short losing bout with leukemia. Buz was always the gentleman, always kind and considerate of his California friends among which I counted myself and a national neurosurgical figure valued by all, particularly the Neurosurgery Research and Education Foundation which he chaired for many years. Losing Buz like this when he appeared poised to enjoy his twilight years with his equally gracious wife Diane, his family and friends makes a great case for agnosticism. ❖

Neurosurgical Positions Available/Wanted

Any CANS member who is looking for a new associate/partner or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a one time posting in this newsletter. Submit your text to me by E-mail (rws-avopro@sbcglobal.net) or fax (858-683-2022). ❖

Executive Office Report

Janine Tash

ATTN: Neurosurgical Residents

Each year, the program directors are contacted for a current list of residents and faculty. Residents automatically become complimentary members of CANS and receive this monthly newsletter as well as other pertinent mailings. We hope that you will join CANS upon completion of your training if you remain in California. Please contact me at janinetash@sbcglobal.net for further information.

Residents are also offered free registration to the CANS Annual Meetings. We strongly encourage you to attend the next meeting January 19-20, 2008 (Grand Californian Hotel in Disneyland) to hear socio-economic topics of interest that will affect your daily practice once you complete your residency.

CANS Working for You

The resolutions of the Council of State Neurosurgical Societies (CSNS) summarized by Dr. Smith in this newsletter are voted on by delegates representing each state. California's delegates are CANS members Drs. William Caton, Thomas Hoyt, Mark Linskey, Donald Prolo, Marc Vanefsky and Patrick Wade. Participation at the CSNS meetings (which are held twice a year) is a good example of how CANS represents its members. The delegates are not reimbursed to attend these meeting, but do so on their own time and at their own expense. ❖

CORRECTION

Our string of errorless newsletters ends at one. In last month's newsletter, we incorrectly identified Dr. Praveen Mummaneni as the director of UCSF's spine fellowship program and spine center. He is actually co-director along with Christopher Ames, M.D. Dr. M correctly identified his co-directorships to us; we simply listed them inaccurately. Apologies to both of these fine surgeons.

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Questions or comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office at janinetash@sbcglobal.net. Past issues of the monthly newsletter are available on the CANS website at www.cans1.org.

The newsletter is a mix of fact, rumor and opinion. The facts are hopefully clearly stated. The rest is open to interpretation. The opinion is mine. R.S. The assistance of Janine Tash and Patrick Wade, M.D. in the preparation of this newsletter is acknowledged and appreciated. If you do not wish to receive this newsletter in the future, please E-mail or fax Janine Tash janinetash@sbcglobal.net, (916-457-8202) with the word "unsubscribe" in the subject line.

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